

Coconino County Health Department



Pandemic Influenza Plan Annex 3

January 2007

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I. INTRODUCTION

This plan will perpetually remain a living document. Updates will frequently be required, as scientific, medical and policy information about potential pandemic influenza changes frequently. This must remain a working document, both to respond to these changes and to keep this plan fresh in the minds of those who will be charged with its implementation.

There is no doubt that this plan will be implemented. Unlike some disaster plans that exist for unlikely events and may never be used, this plan will someday be needed. Historically, an influenza pandemic has occurred a few times each century. Another influenza pandemic will occur, and another after that, and another after that. The severity of such pandemics has varied widely throughout history. It could be that the next pandemic will be no more severe than the last one in 1968, which was relatively mild. On the other hand, it could be as virulent as or worse than the infamous 1918 pandemic. There is no way to know. What we do know is that another will occur, and could occur at any time.

Therefore, completing the detail required for this plan to be smoothly implemented takes on unusual importance, and unusual urgency. This plan will be revised repeatedly as circumstances warrant.

This plan is based upon the framework of the Pandemic Influenza Response Plan created by the Arizona Department of Health Services (ADHS), dated January 2006, which in turn is based upon Federal plans and guidance. Many aspects of Federal guidance, such as explicit prioritization of groups for receipt of vaccine or antiviral medication remain to be established. Therefore, this plan cannot address specifics related to federally generated protocols, but will identify tasks that will be directed by future guidelines where appropriate.

While this plan repeatedly references State and Federal guidance, it is imperative that all public health intervention is ultimately local, and modifications to grander plans must be made at the local level. In addition, it is anticipated that many particular aspects of pandemic response will not be addressed in State or Federal plans and must therefore be addressed on a local level.

The ADHS Pandemic Influenza Response Plan cites the following eight specific responsibilities of local health departments: influenza surveillance and epidemiology; healthcare response and coordination; vaccine and antiviral delivery and administration; community disease control; addressing travel-related risk; public information; continuity of operations; and information management. In addition, the ADHS plan states that it is a local health department responsibility to respond to all crises within their jurisdictions. Each of these responsibilities and more will be addressed in this plan for Coconino County.

A. Objective

The overarching goals of pandemic influenza plans are twofold:

- To minimize morbidity and mortality (illness and death)
- To minimize social disruption

While the Federal and State pandemic influenza plans may speak to issues in general terms, it is incumbent upon local jurisdictions to provide a level of detail that allows for quick implementation. Thus, this plan frequently refers to general issues in the ADHS plan, and either provides necessary detail relevant to Coconino County or describes the need for such detailed planning.

Potentially, the two most effective tools available to achieve the goals of the pandemic influenza plan are vaccine and antiviral medication. However, for reasons that will be discussed below, these tools are unlikely to be available in adequate supply. Thus, the interventions that the Coconino County Health Department (CCHD) will need to employ will be varied and may be seen as dramatic. While the use of these tools will be graduated depending upon the severity of the pandemic, and many may not be employed as circumstances warrant, it is important that elected officials, partner agencies and organizations, and the media be aware of these options so as not to be surprised by their sudden implementation if necessary. One of the important purposes of this plan, therefore, is to educate officials and the community as to the options that may be considered by the County Health Officer.

B. Potential Impact on Coconino County

The ADHS 2004 population estimate for Coconino County is 129,570. This does not include a sizable population of tourists and other travelers. There is one major population center, the City of Flagstaff, with a number of other communities scattered across an enormous geographic area. Large sections of the county are tribal lands.

Nationally, the estimated mortality from an influenza pandemic, depending on a multitude of factors but especially upon the virulence of the pandemic strain, varies anywhere from approximately 104,000 to 2.2 million. Hospitalizations could vary from 360,000 to 9.6 million. Outpatient visits have been estimated at anywhere from 20 million to more than the maximum capacity of the health care system.

Proportionally, Coconino County could suffer anywhere from 40 to nearly 1,000 deaths. Many more would suffer serious illness, with anywhere from 160 to 4,300 hospitalizations. Outpatient visits would be at least 9,000 and could reach an incalculable number.

Assuming that the length of a pandemic wave is three months, the majority (2/3) of the infections occur in the second month and 1/6 of the infections occur in month one and three, the potential impact of pandemic influenza can be estimated with a rate calculation. It is also estimated that half of the population hospitalized for this influenza strain will die.

In a moderate influenza pandemic, such as the 1958 or 1968 pandemic, where the infection rate was estimated to be about 30 percent but with only two percent needing hospitalization, we can estimate the impact on Coconino County within the three month period:

- 39,000 people could become ill with the pandemic flu strain
- 19,500 could seek outpatient care

- 390 could be hospitalized
- 60 could be admitted to ICU
- 29 could require mechanical ventilators
- 195 could die

In the most severe month, this may amount to as many as 260 people admitted to the hospital, with an average of 63 admitted per week or nine people per day. An estimated 130 deaths could occur in month two, with about 30 deaths per week or 4 deaths per day.

In a severe influenza pandemic, such as the 1918 pandemic, where the infection rate was estimated to be about 30 percent with nearly 22% needing hospitalization, we can estimate the impact on Coconino County within the three month period:

- 39,000 people could become ill with the pandemic flu strain
- 19,500 could seek outpatient care
- 4,290 could become hospitalized
- 644 could be admitted to the ICU
- 323 could need mechanical ventilators
- 2,145 could die

In the most severe month, this may amount to as many as 2,860 people hospitalized, with an average of 667 admitted per week or 95 per day. An estimated 1,420 deaths could occur in month two, with about 323 deaths per week or 46 deaths per day.

These numbers do not include deaths NOT due to influenza, and the tourist or visitor population is unaccounted for. Therefore, the true impact could extend beyond these projections.

In addition to obvious health care costs, an enormous cost could be paid due to lost productivity and the disruption of the local economy, especially the tourism and travel-related industry. Many of these deaths, illnesses and much of the economic and social disruption may be preventable with timely, appropriate public health interventions.

C. Planning Assumptions

- An influenza pandemic is inevitable.
- A novel influenza virus strain will likely emerge in a country other than the U.S., although a novel strain could first emerge in the U.S.

- Although there may be isolated pockets, the pandemic will almost certainly affect Coconino County.
- With the emergence of a novel strain, it is likely that all persons will need two doses of vaccine to achieve optimal antibody response (discussed further later in this plan). However, when the pandemic occurs, vaccines and antiviral medications will be in short supply and will need to be allocated on a priority basis.
- The Federal government will assume responsibility for devising a liability program for vaccine manufacturers and persons administering the vaccine (although such a system is not yet complete).
- According to CDC guidelines, total vaccine supply will be under the control of the Federal government, with states receiving an allotment, and local health departments within Arizona receiving an allotment from ADHS.
- At best, Coconino County will receive an allotment proportional to its fraction of the total population in Arizona as vaccine becomes available.
- Temporary residents, visitors, migrant workers and tourists will create a potential population much larger than that of the permanent resident population.
- The response to an influenza pandemic will require the substantial interaction of both public and private agencies beyond CCHD and ADHS.
- Response to demand for services will require non-standard approaches, including:
 - Discharge of less critically ill hospital patients
 - Expansion of hospital capacity
 - Adjustment of patient-to-staff ratios in hospitals
 - Recruitment of volunteers to supplement health care and public health staff
 - Relaxation of practitioner licensure requirements (as directed by ADHS and State licensure agencies)
 - Utilization of alternative sites for health care, isolation and quarantine
 - Expansion of mortuary services capacity
- General guidelines and information templates, including fact sheets, triage and treatment protocols, and guidelines for distribution of antiviral agents will be provided by ADHS, but the county will need to individualize these templates, including local numbers.
- General public information messages will be provided by ADHS.

- Secondary bacterial infections following influenza illness may stress antibiotic supplies.

D. Pandemic Influenza Phases

Pandemic Influenza response is divided into phases based on the 2005 World Health Organization (WHO) plan. These phases are:

Interpandemic Period

Phase 1: No new influenza subtypes in humans, low risk of human infection from existing animal subtypes

Phase 2: No new influenza subtypes in humans, but a circulating animal subtype poses substantial risk of human disease

Pandemic Alert Period

Phase 3: Human infection(s) with a new subtype, but rare or no spread between persons

Phase 4: Small cluster(s) with limited human-to-human transmission

Phase 5: Larger cluster(s) but spread is still localized, suggesting virus is not yet fully transmissible (substantial pandemic risk)

Pandemic Period

Phase 6: Pandemic: increased and sustained transmission in general population

Postpandemic Period

Phase 7: Return to interpandemic period

Within these seven response phases, this plan describes each of the eight essential components of a pandemic response as defined by the ADHS plan. These activities are:

Surveillance and Epidemiology

Epidemiology is the core science of public health. Correct understanding of the nature of the pandemic strain of influenza will be essential to selecting the appropriate public health interventions at the local level. Surveillance of the pandemic as it enters and spreads throughout Coconino County will be key to a timely response. To accomplish this, surveillance methods will need to be modified at different phases of the epidemic.

Healthcare Response Coordination

This includes all planning and preparation related to any aspect of response which includes hospitals and other healthcare agencies and providers.

Vaccine and Antiviral Delivery and Administration

Vaccine and antiviral medications will be the most effective and most useful tools available to CCHD as it attempts to control the pandemic. However, as detailed below, it is doubtful that adequate supplies of either will be available. Thus, while Coconino County is experienced at establishing public vaccine clinics, and has in place plans and protocols for delivering both mass vaccination and mass medication distribution clinics, it is unlikely that there will be an opportunity to fully use this capability during an influenza pandemic. Furthermore, the effectiveness of vaccine or antiviral to a particular pandemic strain cannot be known in advance. For these reasons, mass vaccination or treatment will not be relied upon as a primary solution to an influenza pandemic.

Community Disease Control

All aspects of coordination and emergency response not specific to healthcare response coordination will be outlined in this section. This includes all regulatory and educational measures geared toward minimizing the transmission of influenza among the population, including isolation, quarantine, closure of group activities and other steps to increase “social distancing.”

Addressing Travel-Related Risk

Minimizing unnecessary travel, and possible screening of travelers, may be imposed by the Federal and State governments to slow the spread of pandemic influenza between regions, states or counties. This may involve CCHD, especially early in the pandemic before numerous cases have occurred in Coconino County or before self-imposed decreases in travel naturally occur.

Public Information

This includes internal communications and training, as well as communication with the health care system, other agencies, and the general public. The most important factor in the control of the pandemic may well be the actions of essential service providers and the public at large. Therefore, timely, clear, and believable communication may be the most critical component of CCHD activities. While Federal and State messages will be crucial, and local communication must remain consistent with the messages from larger jurisdictions, CCHD will need to tailor these messages to local circumstances.

Continuity of Operations

This refers to the Continuity of Operations Plan (COOP) as outlined in the *All Hazards Plan, Section 7.0*, continuity of operations unique to the preparation, response and recovery to an influenza pandemic are outlined. Much of this section refers to psychosocial support and pandemic response training of CCHD staff.

Information Management

This refers to the use of specific data systems for information management during a pandemic.

II. CONCEPT OF OPERATIONS

A. Organizational Roles and Responsibilities

The roles and responsibilities of Coconino County will be defined in consultation with ADHS, where appropriate.

Coconino County Health Department by Position

Health Officer (Director of CCHD)

- Activates Department Operations Center (DOC)
- Recommends activation of the County Emergency Operations Center to Emergency Services Coordinator and/or Board of Supervisors
- CCHD Representative to the EOC
- Determines isolation, quarantine, and social distancing measures
- Requests Board of Supervisors to request vaccines, antivirals and medical supplies
- Activates immunization or medication clinics and other CCHD activities

Assistant Director

- Advises the Director regarding policy decisions
- Coordinates and ensures the assignment of public health roles in the Incident Command Structure (ICS) at the EOC and DOC

Public Health Emergency Preparedness Senior Manager

- Available as liaison as assigned
- Provides logistical support to departmental activities
- Maintains communication with hospitals and first responders
- Provides back-up to Communications & Training Manager

Communications and Training Manager

- Coordinates training and assigns duties for volunteers, staff and reassigned staff
- Ensures availability of and training for communications equipment

Community Relations Manager

- Maintains communication with local media
- Maintains phone bank messages and other public information
- Institutes public outreach and education
- Coordinates the distribution of information packets to health care facilities, schools, colleges, major employers, social service agencies, public housing agencies, senior living facilities, etc.

County Epidemiologist

- Oversees surveillance activities
- Activates Coconino Outbreak Response Team (CORT)
- Coordinates and assigns duties related to case investigations
- Performs descriptive epidemiology and prepares reports
- Provides daily status reports to Director
- Evaluates effectiveness of intervention activities
- Reviews and processes reports of vaccine adverse events
- Performs Disease Investigator functions as necessary

Disease Investigator

- Interviews suspect and confirmed cases and contacts as directed
- Educates cases and contacts during interview
- Completes appropriate disease investigation forms
- Provides daily reports to the County Epidemiologist

Finance Unit (Senior Administration Manager)

- Maintain personnel records
- Maintain all financial records (expenditures)
- Ensure ability to purchase needed supplies

- Oversee contracts and agreements

Other staff will perform duties as assigned or prescribed in other plans

B. Scope of Operations

Coconino County

CCHD general roles

- Coordinate the local public health response in conjunction with Coconino County Emergency Services and in consultation with ADHS
- Conduct surveillance in accordance with the existing influenza surveillance system and the expanded system as detailed by pandemic phase in this plan
- Provide health advisories to the public including vulnerable populations (e.g., elderly, developmentally disabled, low-income, etc.)
- Provide public information within the local community
- Implement immunization or antiviral medication distribution
- Implement mass fatality management
- Assist special needs populations
- Implement isolation and quarantine, cancellation of public events, or other actions as detailed by pandemic phase in this plan
- Implement mass care plans
- Maintain communication with ADHS

Coconino County Board of Supervisors

- Activate Emergency Operations Center (EOC)
- Declare County Emergency
- Request Governor to declare State of Emergency, if not already done
- Request influenza vaccine, antiviral medication and medical supplies from State EOC

Coconino County Public Information Officer (PIO)

- Implements phone bank in coordination with CCHD

- Coordination of press release(s)

Reference Plans

The Pandemic Influenza Plan is an annex to the *Coconino County Health Department All Hazards Plan* (Annex 3). This plan will be implemented in tandem with the *All Hazards Plan*. Particular sections of response to Pandemic Influenza may call for reference to specific sections of the *All Hazards Plan* or other annexes to the *All Hazards Plan*. The following annexes may have relevance to this plan:

- Outbreak Response Plan, Annex 1
- Mass Prophylaxis and Immunization Plan/Smallpox Plan, Annex 6
- Strategic National Stockpile Plan, Annex 4
- Mass Fatality Plan, Annex 7

Organizational Issues

Response to an influenza pandemic will require the coordination of multiple agencies. Those agencies include:

Primary Agencies:

Local:	Coconino County Board and Manager's Offices Coconino County Emergency Services / Public Works (CCES/PW) Coconino County Health Department (CCHD)
State:	Arizona Division of Emergency Management (ADEM) Arizona Department of Health Services (ADHS)
Tribal:	Havasupai Tribe Hualapai Tribe Hopi Tribe Kaibab-Paiute Tribe Navajo Nation San Juan Southern Paiute
Federal:	Centers for Disease Control & Prevention (CDC) Indian Health Service (IHS)

Support Agencies:

Local:	Coconino County Community Services Department Coconino County Sheriff's Department Community Health Centers
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Emergency Medical Service (EMS) Organizations
Fire Departments
Flagstaff Medical Center
Native Americans for Community Action (NACA) Clinic
Northern Arizona Regional Behavioral Health Authority (NARBHA)
Page Hospital
Police Departments
Private Medical Clinics
Private Pharmacies
School Districts
Tuba City Regional Medical Center
Urgent Care Clinics
Williams Clinic

State: Arizona Department of Economic Security (DES)
Arizona Department of Public Safety (DPS)
Arizona Department of Transportation (ADOT)
Arizona Governor's Office
Arizona National Guard
Arizona Department of Health Services (ADHS)

Federal: Federal Emergency Management Agency (FEMA)
National Disaster Medical System (NDMS)
U.S. Public Health Service

Voluntary: American Red Cross (ARC)
CERT (Flagstaff and Tuba City)
Coconino County Health Department Volunteers
Interfaith Council (to assist w/education, information and identifying/securing use of large meeting facilities)
Salvation Army
Service Organizations
United Way

Associations: Arizona Medical Association
Arizona Nurses Association
Arizona Pharmacists Association

III. PHASES OF OPERATION

A. Prepare—Interpandemic: Phase 1 and Phase 2

Surveillance & Epidemiology

There is a global surveillance system in place for influenza. This system exists both to identify particular strains of influenza as they circulate, as well as to approximately quantify influenza activity in a timely manner. In the United States, this system operates from October through

mid-May, although it is likely that it will become year-round in the near future. The CCHD Epidemiologist will assure the weekly collection and transmission of data from sentinel sites to the web-based sentinel surveillance system. The CCHD Epidemiologist will monitor this data.

The CCHD participates in this Federal and State surveillance system. The CCHD Epidemiologist is the responsible position for coordinating and conducting this surveillance within the County. The primary component of this system in Coconino County is sentinel provider influenza-like illness surveillance. CCHD also tracks reports of confirmed influenza cases from healthcare providers and the State lab. See below.

For many diseases, mandatory reporting of individual cases as they are diagnosed forms the backbone of surveillance. Influenza, however, is *not* a reportable disease. Influenza spreads too rapidly and affects too many persons for individual case reports to be either timely or remotely accurate. Thus, the U.S., including Arizona, relies upon a routine influenza surveillance system with five components:

- Laboratory surveillance including rapid lab tests performed by healthcare providers.
- Influenza-like illness (ILI) surveillance, conducted among volunteer outpatient “sentinel sites”
- Pneumonia- and influenza-related mortality surveillance
- Overall assessment of influenza activity on a state-by-state basis, in which the State Epidemiologist declares on a weekly basis that the level of activity is:
 - No activity
 - Sporadic
 - Local
 - Regional
 - Widespread
 - (While these categories employ standard definitions, the designation among these categories remains somewhat subjective and is supported by evidence that may be anecdotal.)
- Influenza-associated pediatric mortality

The primary component of this system in Coconino County is sentinel provider influenza-like illness surveillance. CCHD focuses on the first two of the above, sentinel surveillance and lab surveillance. For the 2005-2006 influenza season, CCHD has four sentinel sites: two urgent care centers (Concentra Urgent Care and Walk-In Urgent Care), Fronske Health Center at Northern Arizona University, and North Country Community Health Center, all in Flagstaff. This greatly exceeds the national standards for enrollment of health care sentinel sites for

influenza (one for every 250,000 persons or one per county). Nevertheless, the CCHD Epidemiologist continues to recruit additional sites, especially hoping for coverage of Tuba City, Grand Canyon National Park and Page. The CCHD Epidemiologist also offers to provide flu kits to healthcare providers; train healthcare providers on use; collection of lab samples and submission.

In addition, the CCHD Disease Investigator performs active surveillance for levels of influenza-like illness (ILI) in health care settings during the typical influenza season, including among school nurses. CCHD also provides influenza test kits to healthcare providers, trains providers in the use of such kits for sample collection and submission, and monitors reports of confirmed influenza from healthcare providers and the State Lab.

The CCHD Epidemiologist will ensure the full implementation of MEDSIS (the ADHS electronic reporting and surveillance system) among hospitals and other appropriate reporting sources. The CCHD Epidemiologist will also utilize this system for routine disease surveillance. The CCHD Epidemiologist will assure redistribution of Arizona Health Alert Network messages, thereby reinforcing familiarity with the system among partners.

The CCHD Epidemiologist, or the Coconino County Health Director or designee, will participate with ADHS in developing protocols for institutional outbreaks. This will incorporate existing experience that CCHD has in past outbreaks. CCHD has an Outbreak Response Team (Coconino Outbreak Response Team, or CORT) with assigned roles and responsibilities that may be called upon to assist the usual surveillance staff consisting of the County Epidemiologist, Disease Investigator, and half-time Disease Investigator (See *Outbreak Plan, Annex 1*).

The CCHD Epidemiologist, or the Coconino County Health Director or designee, and the County Medical Examiner will coordinate for rapid collection of death certificates and related information for infectious disease deaths, especially influenza.

Healthcare Response Coordination

There are three hospitals in Coconino County, one each in Flagstaff, Page, and Tuba City. In addition, there are two Community Health Centers: North Country Community Health Center with clinics in Flagstaff, Ashfork, and Grand Canyon Village; and Canyonlands Community Healthcare with clinics in Kaibeto, Fredonia and Page. There are two urgent care clinics and the Native American Community Action Clinic in Flagstaff, a community clinic in Williams and a clinic in Leupp. As discussed in later sections, initial stockpiles of antiviral and antibiotic medication within hospital pharmacies will be assessed. CCHD is responsible for maintaining and tracking the inventories of medication stockpiles.

The Coconino County Health Director or designee will participate in the Arizona Emergency Preparedness and Response Public Health Region Committee. As part of this activity or in addition, the Public Health Emergency Preparedness (PHEP) Senior Manager or designee will hold meetings, jointly or separately, with either the Chief Executive Officer or Chief Operating Officer at each hospital, urgent care center and walk-in clinic to establish contingency plans for pandemic influenza. These plans will include an inventory of available supplies such as surgical masks, N95 masks, and hand disinfectant and recommendations for stockpiles within each

facility. The PHEP Senior Manager and hospital leadership will review surge capacity, develop recommendations, and reach appropriate agreements to share information, including the establishment of multiple redundant lines of communication. Each hospital will participate with the health department in drills for surge capacity response.

CCHD has a volunteer system already in place, and the Communications and Training Manager is responsible for assuring a just-in-time training system for volunteers. Existing volunteers include a number of health care workers, including more than 100 nurses. Some of these volunteers are retired and expected to be available during an emergency, such as an influenza pandemic. In addition, nursing students and faculty from both Coconino Community College and Northern Arizona University are likely volunteers during an emergency.

The Coconino County Medical Examiner works for the CCHD, which facilitates both planning and operations related to mass casualties and surge capacity for mortuary services. The *Mass Fatality Plan* includes a section on “mega” mass fatality for pandemic influenza preparedness planning (See *Annex 7*).

Vaccine & Antiviral Delivery & Administration

During the pre-pandemic phase, the CCHD will continue to provide routine vaccinations as appropriate, including influenza and pneumococcal vaccines, during the usual influenza season. Since these clinics will be conducted using routine operating procedures, no additional training is needed.

CCHD has extensive experience conducting vaccination clinics, including clinics responding to influenza. During regular influenza seasons, CCHD is the primary provider of public flu shot clinics in the county. CCHD is prepared to operate mass vaccination clinics should large amounts of pandemic influenza vaccine unexpectedly become available. This is important because issues such as staffing, training, equipment, supplies, transportation, disposal of needles and other wastes, and related issues are already addressed and practiced. Written agreements for utilization of multiple sites for mass vaccination clinic use will be pursued. During the pre-pandemic phase, plans for mass vaccination clinics will continue to be refined. CCHD will build on its participation in previous drills related to similar issues to develop more specific drills as plans are finalized. Existing plans, such as the *Mass Prophylaxis and Immunization Plan/Smallpox Plan Annex 6*, include details for expanding capacity to any potential size. CCHD Staff and volunteers will be continually trained in their roles in a mass vaccination setting as plans are refined.

The supply of vaccine and antivirals is likely to be extremely limited during an influenza pandemic, especially in the early stages. Therefore, mass vaccination plans will be less important than plans for the distribution of limited supplies of vaccines and antivirals to high priority populations. CCHD will be charged with carrying out policy detailed at the State and Federal levels for sequential, prioritized administration of vaccines and antiviral medications as supplies become available. Subsequent sections will describe issues expected and plans to respond. During the pre-pandemic phase, CCHD will complete preparations for the handling of anticipated events, including the delivery of limited vaccines and antivirals in a prioritized fashion to healthcare and immunization providers. In addition, CCHD will develop plans to

rapidly vaccinate its own staff and families of staff, as well as those of other prioritized partner agencies. As of August 2006, Flagstaff Medical Center has established vaccination distribution priorities and procedures for their own staff.

CCHD will make a concerted effort to encourage routine influenza vaccination of health care workers. In addition to the usual public information regarding influenza vaccine, outreach efforts to the health care worker community by CCHD will emphasize its special duty related to the prevention of influenza transmission. The greater the routine use of influenza vaccine and the greater the capacity for employee vaccination within health care institutions, the easier the response will be during a pandemic.

Community Disease Control Coordination

CCHD works with four different physicians who act as “Medical Director” for particular public health issues, one each for Immunizations, Communicable Diseases, Emergency Preparedness and Reproductive Health. The first three of these physicians may be called upon by the CCHD Director for official needs related to an influenza pandemic.

Due to the anticipated inadequate supply of vaccine and antivirals, the CCHD Director must consider other public health interventions, depending on the severity of the pandemic. CCHD recognizes the significant opportunity offered during the pre-pandemic phase to educate strategic individuals about the potential use of these alternative interventions. At a minimum, the stakeholders involved will include elected officials, attorneys for public agencies, key law enforcement personnel, and possibly public utility officials, the news media, and business representatives such as Chambers of Commerce. CCHD has already begun this process and will continue during the pre-pandemic period in order to adequately inform partners prior to implementation. Preparing key stakeholders for these possible contingencies ahead of time will allow for their smooth implementation with little delay and resistance.

As part of this process, feedback has already been obtained from participants in community training sessions, and an ongoing Pandemic Influenza Coordinating Council (PICC) has been formed. Issues that may be addressed include isolation and quarantine implementation criteria and procedures; establishment of social distancing measures that may be taken and when and how these measures may be implemented; continuity planning for area businesses and government agencies for extended emergencies. Plans for provision of medical evaluation of persons presenting with influenza-like illness (ILI) will also be discussed with PICC. In addition, CCHD will work with the PICC to develop tools and mechanisms to prevent stigmatization and provide mental health services to persons in isolation or quarantine, as well as to family members of affected persons and other community members.

The CCHD Director or designee will work with the County Attorney, law enforcement agencies, judges and elected officials to develop and ensure an understanding of procedures for isolation and quarantine, social distancing measures and other restrictions of movement.

Addressing Travel-Related Risk

Travel-related disease containment measures will be included in the planning noted in the preceding paragraph, above. The Director or designee will assure that appropriate staff

understands their roles in such plans. The PICC will contribute to and be aware of issues arising from such plans. The Community Relations Manager will work with the local travel industry, including hotels and motels, to assure an awareness of these and other plans that will impact their businesses.

Public Information

Timely and informative communication will be central to a successful response to an influenza pandemic. This includes communication among responding agencies and providers as well as the general public. The pre-pandemic phase allows time to prepare for adequate communication during a pandemic. The CCHD communications staff include: the Community Relations Manager, who serves as the Public Information Officer (PIO), and the Communications and Training Manager, who serves as the back-up PIO. The *CCHD All Hazards Plan, Section 2.0* should be referenced for complete public information plans. The CCHD communications staff will gather and organize fact sheets and other existing information on pandemic influenza and add them to the *CCHD All Hazards Plan, Section 2.0*. Prepared messages and fact sheets will be available in English and Spanish.

The Communications and Training Manager will identify and train lead subject-specific spokespersons as necessary, and will provide appropriate CCHD staff with training on risk communication.

The Community Relations Manager will further develop and maintain existing contacts with the media and community partners. During pandemic influenza exercises, the Community Relations Manager will participate so as to evaluate the adequacy of these contacts and prepared messages.

The Community Relations Manager, the Public Health Emergency Preparedness (PHEP) team and the CCHD Director will identify any further communication resources that may be needed during a pandemic and assure that these are in place.

There is an existing recorded information line, and the capacity for seven phone lines in a telephone information call center. There is a mechanism for hiring temporary help to staff this call center, and up to three temporary employees have been hired for this purpose in the past.

Continuity of Operations

CCHD will stress individual and family preparedness prior to an event. Public Health Emergency Preparedness (PHEP) team will conduct biannual presentations on individual and family emergency preparedness to all CCHD staff at the May and September staff meetings. Additionally, individual and family preparedness materials are made available to all CCHD staff and area businesses at <http://www.coconino.az.gov/health.aspx?id=2588>. These materials will be mailed, through inter-departmental mail, to all CCHD staff annually.

The County Employee Assistance Program (EAP) through the Flagstaff Child and Family Counseling Center will be routinely available. Each staff member may receive six counseling sessions for themselves, spouses or children. However, during an influenza pandemic, this service may quickly reach its capacity. Therefore, relationships will need to be established with other behavioral health agencies to provide counseling that exceeds EAP capacity.

One of the best ways to reduce employee stress and absenteeism during an extended public health emergency is to emphasize the critical value of each staff member during an emergency and to also clarify the role-specific expectations during an emergency for each staff member. Training and briefing of health department staff on emergency response prior to an event will reduce absenteeism, lessen the psychosocial burden experienced by staff during the response and improve response quality. Training of all CCHD staff will include: use of ICS and NIMS in an emergency, finding resources to be used in a public health emergency, family emergency preparedness, and cultural competency. Please refer to the *CCHD Training Plan* for further detail on staff training.

The CCHD Director or designee will work with the Northern Arizona Regional Behavioral Health Agency, Flagstaff Children's and Family Counseling Center and the American Red Cross to identify potential needs and responses for staff during and following an influenza pandemic. Material that may be supplied by ADHS or other entities will be gathered for employees' use during a pandemic. The PHEP team, along with the CCHD Director will establish workforce resilience programs that will help staff to prepare for, cope with, and recover from the social and psychological challenges of emergency work. Workforce resilience programs will address:

- Ensuring that administrators, managers, and supervisors are familiar with and actively encourage the use of tools and techniques for supporting staff and their families during times of crisis.
- Training staff in behavioral techniques to help employees cope with grief, stress, exhaustion, anger and fear during an emergency.
- Developing strategies to assist staff with child-care or elder-care responsibilities or other special needs that might affect their ability to work during a pandemic.
- Identifying additional resources that can be available to employees and their families during and after a pandemic.

The PHEP team will *strongly encourage* all CCHD staff and their families to get their seasonal influenza vaccination each year. An incentive program will be developed to encourage staff and their families to get vaccinated each influenza season.

In agreement with the Coconino County Continuity of Operations Plan (to be drafted FY '07), the CCHD Director or designee will review policies as outlined in the *CCHD All Hazards Plan, Section 7.0* to address employment issues related to illness, sick pay, staff rotation and family concerns specific to an influenza pandemic emergency.

Information Management

The CCHD Epidemiologist will continue to use, participate in the revision and development of, and encourage reporting sources to use MEDSIS (Medical Electronic Disease Surveillance Intelligence System), including the Electronic Laboratory Reporting portion. All CCHD personnel currently on the SIREN communication system will continue its use. Arizona Health Alert Network messages will continue to be monitored and forwarded appropriately as is

currently the case. The CCHD Epidemiologist and the Communicable Disease Specialist will participate in the development of mechanisms to track individuals, whether for vaccine or antiviral recipients, monitoring of those who are in isolation or quarantine, or monitoring other suspected contacts to cases.

B. Alert

Pandemic Alert Period: Phase 3

This phase occurs from time to time and does not always result in a pandemic, and has occurred several times in recent years, primarily in Southeast Asia. The current H5N1 strain of avian influenza, as of August 2006, presents this level of threat.

Surveillance and Epidemiology

Following a Pandemic Alert Phase 3 notification, the CCHD Epidemiologist will continue routine influenza surveillance and attempt to increase interest among certain providers in participating as a sentinel site or to enlist as a stand-by pandemic surveillance site. The CCHD Epidemiologist will also request that providers, even those not participating as sentinel sites, enhance surveillance for specific epidemiologic factors as directed by ADHS (e.g., travel to affected areas) among persons with influenza-like-illness (ILI). The CCHD Epidemiologist will request that detection of any such factors be reported to CCHD and will in turn immediately report such findings to ADHS. In response to any such reports, the CCHD Epidemiologist will assure completion of investigations, obtaining specimens for submission to the State Laboratory and monitoring of close contacts for ILI.

The CCHD Epidemiologist will monitor sentinel and syndromic surveillance sources and evaluate the level of activity. The CCHD Epidemiologist and the Community Relations Manager, as appropriate, will assist with the distribution of epidemiologic reports of influenza activity to partners. The CCHD Epidemiologist and the CCHD Director or designees, will participate in pandemic alert conference calls regarding surveillance or other matters with ADHS and other local health departments.

Healthcare Response Coordination

All activities performed during the Interpandemic Period will continue. In addition:

The CCHD Epidemiologist and the CCHD Director will remain in contact with ADHS, through conference calls or other means, to monitor the progress of the situation. Healthcare partners will be regularly informed by the CCHD Epidemiologist, Community Relations Manager, CCHD Director or designee as appropriate.

The CCHD Epidemiologist or designee will contact healthcare providers in Coconino County about their progress in adherence to Influenza Infection Control Guidelines as provided by the Centers for Disease Control and Prevention (CDC). An infection control guidelines needs assessment form was mailed to 63 healthcare providers in Coconino County in June 2006 to assess the preparedness progress of each clinic or hospital. CDC infection control guidelines for healthcare providers were also mailed. Please refer to *Appendix D* for survey results.

Vaccine and Antiviral Delivery and Administration

All activities performed during the Interpandemic Period will continue. It is unlikely that any vaccine will be available or indicated during this phase. Please refer to *Appendix A* for more information on issues related to pandemic influenza vaccination production. During this Pandemic Alert Period, however, special attention will be given to promoting seasonal influenza vaccinations amongst at-risk populations and the general population. Antiviral medication will be available in the private sector but will not be advisable for use other than usual indications of seasonal influenza.

Community Disease Control

All activities performed during the Interpandemic Period will continue.

Addressing Travel-Related Risk

All activities performed during the Interpandemic Period will continue. In addition, the Community Relations Manager will provide information to local travelers who visit countries where novel influenza strains have been reported to be infecting humans.

Public Information

The Community Relations Manager will maintain communication with the ADHS PIO in order to evaluate and assure consistency of messages. The Community Relations Manager will begin disseminating messages and materials to improve the knowledge and understanding of the CCHD staff, public, healthcare professionals, policy-makers, media, and others about aspects of pandemic influenza and its response.

The Community Relations Manager will monitor media and other sources for rumors and false reports regarding pandemic influenza threats and will seek to counter these.

Continuity of Operations

All activities performed during the Interpandemic Period will continue.

Information Management

All activities performed during the Interpandemic Period will continue.

Pandemic Alert Period: Phase 4

It is possible that a highly transmissible strain of influenza may leap from Phase 3 to a Pandemic in a very short timeframe, essentially skipping this phase.

Surveillance and Epidemiology

CCHD will notify providers participating as sentinel surveillance sites of the Pandemic Alert. If not already operating, (i.e., if not already during the usual influenza season) the CCHD Epidemiologist will activate the sentinel surveillance system. The surveillance staff will

maintain regular communication with sentinel site providers regarding routine procedures as well as special requests for surveillance distributed by ADHS.

The surveillance and communications staff will work together to distribute World Health Organization (WHO) and/or Centers for Disease Control and Prevention (CDC) information on the Pandemic Alert to other selected health care providers and institutions along with a request for additional volunteer sentinel sites in light of the increased concern about a potential pandemic. The CCHD Epidemiologist, with the assistance of the CCHD Director or one of the Medical Directors, will appeal to all hospital emergency departments, urgent care centers and walk-in clinics to participate.

The CCHD Epidemiologist will request healthcare providers to screen travelers arriving from influenza-affected areas for influenza-like-illness (ILI). Any such reports will be followed-up as described in Phase 3. The CCHD Epidemiologist will collect and analyze demographic data on any reported clusters, ill travelers, or unusual cases.

In consultation with ADHS, the CCHD Epidemiologist may initiate active surveillance for hospitalized persons with ILI, or for influenza-related deaths.

Healthcare Response Coordination

All activities performed during the Interpandemic Period will continue. In addition:

The CCHD Director will ensure that local elected officials, partner agencies, hospitals and healthcare providers are advised of the status of the alert. The CCHD Director will request that stakeholders (including the Coconino County Health Department Senior Management, Coconino County Emergency Services Department, and the Pandemic Influenza Coordinating Council) review this plan and supporting materials.

Vaccine and Antiviral Delivery and Administration

Upon notification of this phase of a Pandemic Alert, the Clinical Services Senior Manager will review plans for vaccine administration before it arrives. All volunteers and staff that will be used in a mass immunization or treatment effort will be contacted by the Communications and Training Manager to assure their availability and to advise them to review their training manual, and asked to contact the Communications and Training Manager should their availability status change.

The Clinical Services Manager will obtain the latest ADHS recommendations of priority groups for vaccine allocation and, in conjunction with the CCHD Epidemiologist and with the CCHD Director, will expand the level of detail and modify the priority list as necessary based upon current surveillance data and projections for vaccine availability.

The CCHD Director will request hospital and private pharmacies in the area to provide an inventory of antiviral medication on hand to the Clinical Services Manager, to include adamantanes (amantadine and rimantadine) and neuraminidase inhibitors (oseltamivir and zanamivir). While all pandemic strain vaccines will be federalized and distributed to CCHD through ADHS, much of the antiviral medication supply will be privately distributed through the

health care system. It will be important for CCHD to keep track of the approximate available supply.

Community Disease Control

All activities performed during the Interpandemic Period will continue.

Addressing Travel-Related Risk

All activities performed during the Interpandemic Period will continue.

Public Information

All activities performed during the Interpandemic Period will continue. Upon notification of this phase of a Pandemic Alert, the Community Relations Manager will review the Crisis Communication Plan and prepare for its implementation. Fact Sheets on Pandemic Influenza will be reviewed, revised and translated along with other information.

As a pandemic becomes increasingly imminent, the CCHD staff will be looked upon by their family, friend and neighbors as sources of information. The PIO or designee will spend significant time educating all CCHD staff on effective risk communication and about influenza, avian influenza and pandemic influenza.

Continuity of Operations

CCHD staff will be briefed on the WHO change in pandemic alert status and the potential implications this status change may have on Coconino County. Staff emergency response training will occur more frequently. Particular emphasis will be put on family preparedness and the role each staff member will play in the emergency response. This plan (Pandemic Influenza Plan) will be made readily available to all CCHD staff members and a planned “walkthrough” of a pandemic scenario will occur. The purpose of such a “walkthrough” will be to identify inconsistencies and/or areas of confusion. The Director and the PHEP team will make arrangements for all CCHD senior managers and program managers to participate in risk management training that addresses communicating with staff during a crisis.

Staff will be reminded of the basic infection control precautions (e.g. “Wash Your Hands and Cover Your Cough”). The PHEP unit will make arrangements to have alcohol hand gel and disinfectant wipes available and accessible at all entrances to CCHD facilities and to all staff (particularly in each staff member’s work station). The CCHD epidemiologist will develop a mechanism to track CCHD employee daily absenteeism due to ILI.

The Director and the PHEP senior manager will review the COOP as outlined in the *CCHD All Hazards Plan, Section 7.0*. Based on WHO and CDC information on the virulence of the potential pandemic influenza virus, estimates of CCHD human resources needed to respond to the pandemic in Coconino County will be made. From these estimates, initial delineation of CCHD mission essential functions that will be sustained during the potential pandemic will be drafted. The *CCHD All Hazards Plan, Section 7.0* will be referenced to identify the following: CCHD mission essential functions that will continue; CCHD functions that can be suspended

while staff is reassigned to more critical roles; and the critical functions that may be performed via telecommuting.

The Director and the PHEP team will make arrangements for all CCHD senior managers and program managers to participate in risk management training that addresses communicating with staff during a crisis. Additionally, this plan will be made readily available to all CCHD staff members and a planned “walkthrough” of a pandemic scenario will occur. The purpose of such a “walkthrough” will be to identify inconsistencies and/or areas of confusion.

After the sustained CCHD essential functions are identified, operational planning for these functions will begin. The CCHD Director or designee(s) will seek written assurance from ADHS and other funders that contractually funded employees may be utilized for other, pandemic-related duties during a pandemic emergency. In addition, a plan to cross train staff to backfill mission essential functions will need to be developed at this phase by the Communications and Training manager. Coconino County IT staff will be consulted to assess the IT capabilities to support increased telecommuting activities. Technology that maybe needed to support large-scale telecommuting activities include: pre-established conference bridge lines; laptops; VPN access; and information security.

Information Management

All activities performed during the Interpandemic Period will continue.

Pandemic Alert Period: Phase 5

It is possible that this phase may be skipped entirely if the virus mutates to a readily transmissible form.

More detailed exercises will be completed. The EOC will be stockpiling supplies. Education messages will be provided for the public. CCHD will work with hospitals and clinics on triage, surge capacity, and transfer or discharge planning.

At this time, Coconino County will most likely instate the National Incident Management System (NIMS), as described in the *CCHD All Hazards Plan*. From this point forward, duties will be assigned following the Incident Command System (ICS) structure (where applicable).

Surveillance and Epidemiology

The CCHD Epidemiologist or designee will notify providers participating as sentinel surveillance sites of the substantial pandemic risk via blast fax or by the most expeditious means available and distribute any special requests for surveillance from ADHS. The CCHD Epidemiologist and/or surveillance staff will deliver additional supplies for laboratory samples, as appropriate.

The CCHD Epidemiologist, with assistance from the Director or designee, will distribute information on the substantial pandemic risk to other selected health care providers and

institutions along with an urgent request for additional volunteer sentinel sites in light of the imminent pandemic. CCHD will continue promoting and monitoring weekly reports by sentinel providers into the web-based influenza-like-illness (ILI) surveillance system. In addition, surveillance staff will conduct active surveillance of sentinel sites for influenza cases and cases of ILI that fit the case definition of the novel virus strain.

Reports of ILI among tourists will be especially important. Clinics, especially clinics potentially catering to a largely transient population, such as the Grand Canyon Clinic or the Fronske Health Center at NAU, will be urged to screen and rapidly report patients with ILI.

The CCHD Epidemiologist will initiate active surveillance for ILI or increased absenteeism from schools, large employers, or other sites as previously planned.

Other disease investigations will be reprioritized as necessary in order to maintain frequent, active surveillance for influenza. The CCHD Epidemiologist will provide the CCHD Director with daily updates as warranted.

Healthcare Response Coordination

The Incident Commander (IC) will consider activation of the Department Operations Center (DOC). Please refer to the *CCHD All Hazards Plan, Section 4.0* for further guidance of DOC operations. The CCHD Director will notify local officials and partner agencies of the substantial pandemic risk and review arrangements for implementation of the County EOC. The IC will request a meeting of all participants in the County EOC and review various potential scenarios. The primary role of the CCHD Director will be emphasized, and the likelihood of a statewide declaration of a State of Emergency, including the legal ramifications of this, will be discussed.

It is anticipated that beginning with this phase, detailed guidance will be forthcoming from ADHS, based, in turn, upon updates and guidance from the CDC and other Federal agencies. CCHD will schedule conference calls and other forms of communication with all relevant stakeholders. The CCHD Director or designee will participate in all such communications, pass along such information to partner agencies and officials, and be responsible for assuring compliance with regulations as ADHS guidance is adapted to local circumstances.

If vaccines become available during this period, once delivered by ADHS and the Arizona Department of Public Security (DPS) personnel, the Immunization staff will establish vaccination sites in accordance with the following *CCHD All Hazard Plan* annexes: *Mass Prophylaxis and Immunization Plan/Smallpox Plan, Annex 6* and the *Strategic National Stockpile Plan, Annex 4*. The County Sheriff and local police will provide escort and security service.

All prior healthcare response coordination activities will be reviewed for completion by staff tasked to perform these activities in previous phases.

Vaccine and Antiviral Delivery and Administration

The IC will alert the immunization staff of the WHO's Pandemic Alert phase change and brief the immunization staff on the substantial pandemic risk inherent in phase 5. In addition, the IC

and Logistics Chief will call upon selected other clinical staff to assist with vaccination or medication distribution clinics. The immunization manager will provide just-in-time training for clinical staff not routinely involved with immunizations. In order to preserve limited supplies, antiviral distribution will not occur until the pandemic strain has been identified by the County. If vaccine becomes available during this period, CCHD will administer it consistent with a priority list provided by ADHS and the CDC, if available. Additional details of vaccine and antiviral distribution is described in the *Pandemic Phase 6* section below.

The Logistics Chief will alert mass vaccination or medication clinic sites with which agreements exist; final negotiations or arrangements will be completed.

Community Disease Control

At this point, essential businesses and organizations may need to activate their COOP. Essential services in Coconino County include:

- Emergency Medical Services Provider Organizations
 - Private and public ambulance providers
 - Clinics
 - Hospitals
 - Coconino County Health Department
- Public Safety
 - Fire department
 - EMS
 - Law enforcement agencies
- Utilities
 - Water
 - Sanitation
 - Power and electricity
 - Telecommunications
- Basic Needs
 - Groceries
 - General retail stores (e.g. Wal-mart, Kmart, Target)

- Pharmacies
- Transportation Services
 - Gasoline Stations
 - Mass Transit (buses, trains, etc)
- Mortuary Services
 - Funeral homes
 - Embalming/Cremation services
- Communications
 - Media organizations
- Government entity
 - Key government officials
 - Local, state, federal, and/or National Park Services)
- Schools
 - K – 12
 - Colleges and Universities

Addressing Travel-Related Risks

All activities performed during prior phases will be reviewed and will continue.

Public Information

As is the case at all times, the media will be the primary source of health-related news for most of the public. Historically, large epidemics with tragic consequences have not needed to be hyped by the media – the stories hype themselves. It will be important that the media not see the need to exaggerate news in advance or early in a pandemic, as that news may become increasingly alarming without exaggeration. The PIO will provide honest, accurate information to the public in order to best assure public cooperation and minimal social disruption. Other sources of information, such as the 211 system, will be referenced by the PIO as appropriate.

The PIO will check with ADHS to ensure access to the latest documents, fact sheets, and information on the website, including Spanish translations. The PIO will assure proper content, including local relevance. The Logistics Chief will assure availability and access to appropriate material. Spanish speaking staff, as delegated by the PIO, will review documents for readability and understanding prior to distribution.

Individual contact will be made by the CCHD PIO with selected media representatives. Each will be provided with a thorough explanation of pandemic influenza and methods for its control. Communication will emphasize the willingness of CCHD to share all relevant information as it becomes available, and the need for the media, as the primary conveyor of information to the public, to accurately transmit this information.

The Logistics section will initiate any necessary preparation to ready the call center to respond to inquiries and concerns from the public. The Logistics section will provide updated training to all staff that will be reassigned to answer calls on a rotating basis. Refer to *CCHD Training Plan* for details on CCHD staff emergency response training.

The IC will issue, with assistance of the Logistics Chief, internal memos to health department and other public employees updating the situation and describing their special roles and responsibilities.

Continuity of Operations

The change in pandemic alert status to phase 5 will, most likely, prompt the IC to activate the COOP as outlined in the *Coconino County Health Department All Hazards Plan, Section 7.0*. Final decisions on the immediate mission essential functions that will be sustained during the initial stages of the pandemic will be made. The guidelines set forth in the *Coconino County Health Department All Hazards Plan, Section 7.0* will be used in making these decisions along with current recommendations from ADHS, CDC and WHO. Preparation for the internal CCHD response during impending emergency response will include: review of job-action sheets for essential positions, personnel cross training of essential positions, review of just-in-time training plans and reassignment of staff to support either the CCHD mission essential functions or the emergency response preparedness.

Similar to Pandemic Alert Period Phase 4, all CCHD will be briefed on the WHO change in pandemic alert phase and the implications this may have on Coconino County and CCHD operations.

At this phase, select Coconino County personnel policies will be amended to accommodate CCHD and staff needs. Such personnel policies include, but are not limited to:

- Staff Travel

CCHD travel policies will be amended following the general guidelines as outlined in the *Coconino County Health Department All Hazards Plan, Section 7.0*. International and/or domestic travel will be suspended to all areas confirmed or suspected of having human pandemic influenza activity for ALL CCHD staff members. In addition, non-essential travel of ICS-assigned personnel will be suspended.

- Management of Ill Staff

All CCHD staff members will be reminded that they should NOT report to work if they become ill with a contagious disease that may endanger their co-workers, per the *Coconino County Personnel Policy Manual*. All CCHD staff members will be informed

of the case definition(s) of seasonal and pandemic influenza versus the common cold via appropriate internal communications to enable staff members to make appropriate health decisions (see Appendix G).

- Employee Compensation

Employee compensation for over-time work for Non-exempt employees and sick leave as outlined in the *CCHD All Hazards Plan, Section 7.8*. Final decisions on employee compensation protocols will be reviewed by the IC and/or the Planning chief in preparation for COOP activation greater than 30 days.

Information Management

All activities performed during prior phases will be reviewed and will continue.

C. Respond—Pandemic: Phase 6

Once a pandemic is occurring, it will only be a matter of time before it affects the United States, Arizona and Coconino County, perhaps a very short time. The 1918 pandemic was introduced to all parts of the country within four to six weeks, during a period of time that lacked air travel or a highway system. Thus, response and activity during this period is apt to rapidly shift, perhaps in a matter of days, from detection of the introduction of the novel virus to detection of early cases to coping with many cases of disease.

Either prior to or almost certainly upon discovery of cases in Arizona, a declaration by the Governor of a State of Emergency is anticipated.

Unlike many typical influenza seasons, all three pandemics of the last century occurred in two waves peaking months apart. Interestingly, virulence sometimes differed between the two waves, as if some of the virus mutated significantly within a single season. This bimodal epidemic pattern is expected again and provides unique challenges and opportunities. All of the following activities will continue throughout the second wave.

Surveillance and Epidemiology

Once a pandemic is declared, detection of the novel virus in Coconino County will be a high priority. This may be especially difficult if the pandemic occurs during the regular colds-and-flu season, when other influenza-like-illness (ILI) will be occurring. The case definition of ILI as provided by the CDC and/or ADHS will be used for surveillance activities. Surveillance staff will query sentinel sites daily and encourage those collecting specimens to submit specimens from those with ILI up to the maximum limit specified by the State Laboratory.

When the State Laboratory confirms an initial case of the novel virus in a resident or visitor in the County, the CCHD Epidemiologist will immediately report this information following the appropriate ICS chain of command until the IC receives the report. The IC will notify ADHS, CCHD Senior Managers, Coconino County Manager, Coconino County Board of Supervisors and Coconino County Emergency Management Services.

The Disease Investigator or designee will ask any initial case(s) identified for a detailed history of contacts and public places visited during the 24 hours prior to the onset of symptoms. The Disease Investigator or designee will daily monitor close contacts for ILI symptoms and ask them to refrain from public venues during the brief incubation period (although this is up to approximately ten days for the current circulating strain of Influenza A H5N1, it has more typically been three days maximum – whether this aspect of the pandemic strain will match typical, annual influenza cannot be determined in advance). Roles and responsibilities of individual staff in carrying out this activity are further described in the *Outbreak Response Plan, Annex 1*.

Additional staff needs for case investigation will be identified by the CCHD Epidemiologist and/or the Logistics Chief and transmitted to the IC. Identified additional staff and volunteers will be provided basic training by the Logistics Section according to the *Outbreak Response Plan, Annex 1* and *CCHD All Hazards Plan, Section 4.2*. These additional staff will then work under the guidance of the Disease Investigator and CCHD Epidemiologist to perform functions of the Disease Investigator.

The CCHD Epidemiologist or designee will coordinate with ADHS regarding surveillance needs at various points throughout the pandemic. Data will be evaluated as it becomes available, including standard morbidity and mortality analysis on a relevant geographic basis. ILI-related deaths will be tracked with the Medical Examiner. Surveillance activities will be modified at various points during the pandemic with the goal of providing the most useful information to target and evaluate interventions and resource needs.

Once multiple cases of the pandemic strain have been identified within Coconino County, further laboratory confirmation of cases will become irrelevant. Typical surveillance efforts will quickly become overwhelmed. The CCHD Epidemiologist or designee will ask sentinel sites to cease collection of laboratory samples and, if agreeable to ADHS, cases of ILI will be assumed to be of the pandemic strain for surveillance purposes. Depending upon the magnitude or severity of the pandemic, surveillance staff may survey sentinel sites either daily, or two to three times per week to ascertain the extent of ILI seen, and for general demographic characteristics of cases or those most seriously ill. The staff will forward this information to ADHS to evaluate the need to revise priority groups for vaccination and/or administration of antiviral medication. Additional staff and volunteers who had been tasked to disease investigation assistance may be moved to other purposes once the volume of cases renders usual surveillance efforts less critical.

Once vaccination has begun, the CCHD Epidemiologist or designee, in consultation with the Medical Director, will track reports of adverse vaccine reactions and forward these to ADHS and to the national Vaccine Adverse Events Reporting System (VAERS).

If alternative sites for evaluation and treatment of ILI have been established (see *Phase 6-Healthcare Response Coordination* below), these sites will automatically be considered sentinel sites for surveillance purposes.

The CCHD Epidemiologist or designee will report surveillance updates following the ICS chain of command. See the *Outbreak Response Plan, Annex 1* for further information on epidemiological investigations.

Although the bimodal wave pattern is expected, local pandemic influenza activity will likely not disappear completely between the waves. It will remain an important surveillance function to approximately quantify the extent of the epidemic in a timely manner. Exact counts are not necessary for this, but a clear indication that ILI, as defined by CDC, is on the decrease at multiple clinical sites will be important. As soon as a decrease in influenza activity is detected, the CCHD Epidemiologist or designee will report this following the ICS chain of command.

Throughout the period between waves and during the second wave, surveillance activity will continue as it was during the first pandemic wave. Reports from elsewhere regarding the start of a second wave will be used to inform the IC of the potential timing of a second wave in Coconino County.

Healthcare Response Coordination

It will be important to preserve the function of the routine health care system despite the pandemic. The CCHD Senior Manager for Clinical Services will interface with the Hospital and Healthcare Support Group in the ADHS NIMS structure. In consultation with hospitals and large clinics, persons with influenza-like-illness (ILI) will be directed to alternate sites for triage and treatment. Those presenting to the emergency department or certain other clinics with ILI will be directed to such a site. These may be as simple as another entrance to the same facility or a tent or other temporary shelter established outside, or it may be a facility at a different location.

The CCHD Senior Manager for Clinical Services will ensure that healthcare partners receive the latest Federal and State guidance as well as the latest information from CCHD.

Federal and State Distribution of needed medications or other supplies, volunteers or other supplemental staff, and other needs for healthcare providers, first responders, healthcare facilities and other parts of the healthcare system will be addressed via the County EOC in consultation with the ADHS Hospital and Healthcare Support Group.

The Logistics section will assure just-in-time training for previously recruited volunteers and staff assigned to new duties. The Logistics section will coordinate and deploy volunteers. Assignments will be made based on needs determined within the EOC and/or DOC, and may include either public health or health care needs. Of note, CCHD already has a verbal agreement with school districts to utilize school nurses at any time that school is not in session (and it is likely that school may be cancelled during the pandemic phase). There are approximately 16 school nurses at any given time in Coconino County: 12 in Flagstaff and one each in Williams, Page, Grand Canyon Village and Tuba City.

Vaccine and Antiviral Delivery and Administration

As soon as the vaccine becomes available, it will be distributed according to the following CCHD All Hazards Plan annexes: *Mass Prophylaxis and Immunization Plan/Smallpox Plan, Annex 6* and *Strategic National Stockpile Plan, Annex 4*. Prioritization schedules provided by

CDC and/or ADHS will be adhered to as appropriate, and modified as necessary. Hospitals and other large health care facilities may be allocated appropriate amounts of vaccine as per the schedule provided by the CDC and asked to vaccinate their own staff per the prioritization schedule. In such cases, CCHD will request that the hospitals maintain lists of those vaccinated and submit them regularly to the CCHD. Documentation of those persons vaccinated will be maintained using the Vaccine Management System (VACMAN) software provided by ADHS. As noted above, the CCHD Epidemiologist will record and report to ADHS and to VAERS all complaints regarding vaccine adverse events.

Local police departments and/or the Coconino County Sheriff's Department will provide security at all vaccine sites, at any antiviral medication distribution venue, and during transportation of vaccine or antivirals. Law enforcement escort and security of vaccine and antivirals will be coordinated at the EOC. Please refer to *Strategic National Stockpile Plan, Annex 4* for more detail.

Beginning one month after the first vaccination, the Immunization Coordinator will recall all persons vaccinated for a second dose, assuming this remains the recommendation of the CDC and ADHS. If possible, re-vaccination will occur at the same sites where recalled persons were originally vaccinated. The Vaccine Clinic Coordinator will be responsible for assuring the recall.

If the pandemic appears to be leading to an increase in bacterial pneumonia, the CCHD Director or designee will request hospital and other pharmacies to provide an inventory of relevant antibiotics on hand, as guided by ADHS. Should supply be found to be limited, the Director will request further supplies from ADHS, via the Strategic National Stockpile or other resources. Antibiotics received will be allocated to the health care system as supplies allow. Refer to *Strategic National Stockpile Plan, Annex 4* for more detail.

As vaccine becomes more readily available, the Immunization Coordinator will implement mass vaccination plans for the general public.

Community Disease Control

It is anticipated that a State of Emergency will have been declared by the Governor shortly after phase 6 has been affirmed by the WHO. While direction will be taken and followed from ADHS and the State Incident Command Structure, many local policy decisions will be required. Whether or not there is a declared State of Emergency, the Coconino County Emergency Operations Center (EOC) will be initiated and existing County emergency plans will be followed, as applicable. Refer to *CCHD All Hazards Plan, Section 4.3* for further information on EOC operations.

Unlike many emergency situations, an influenza pandemic will persist for months; therefore, the County EOC is not likely to remain fully staffed for the duration of the epidemic. Instead, initial and periodic decisions must be made and a system agreed upon for periodic communication among those at the highest levels of the ICS.

Regardless of the availability of influenza vaccines and/or antivirals, a wide range of social distancing measures will be considered and implemented to limit the spread of infection. These interventions fall into two general categories:

- Voluntary – Public Health advisories to the public to take certain actions.
- Regulatory – The use of Public Health authority to order certain actions, with judicial support as necessary and enforcement of orders by County and City law enforcement agencies

Implementation of both voluntary and regulatory social distancing interventions will depend upon circumstances. Refer to *Appendix B: Graded Implementation of Voluntary and Regulatory Social Distancing Measures* for further guidance.

CCHD will direct the implementation and appeals of voluntary and regulatory social distancing interventions to the public at large. Refer to *CCHD All Hazards Plan, Section 2.0* for more detail on public communication methods.

If the CCHD Director makes the decision to employ isolation and quarantine, decisions will be required regarding where to do so. Isolating a person with ILI at home may force continued exposure among household contacts, especially if these contacts are quarantined in the same residence. To move either the suspect case being isolated or household contacts to another location would require a facility to house them, and would require the availability of caregivers to provide at least minimal care to the suspect case in the absence of household members who otherwise would have performed this function. It is assumed that there will not be adequate hospital or similar health care facilities to house all suspect cases.

Isolation and Quarantine scenarios include:

- Isolation of suspect cases at home, while providing alternate residence for household contacts now under quarantine (with separate room and air handling per household to minimize further transmission), such as a motel room, and providing home care for the isolated suspect case.
- Isolation of suspect cases in an alternate site, such as a motel room, and providing home care in that location, while household contacts remain quarantined at home.
- Isolation of suspect cases and quarantine of household contacts in adjoining motel rooms, thus minimizing repeated exposure, yet allowing for one household member to continue providing basic care.
- Cohorting in larger facilities of either suspect cases or contacts, but this risks the spread of infection among those isolated or quarantined.

CCHD staff who may be assigned to any of the scenarios above include: home health staff, NICP Community Health Nurse, Healthy Families staff and Health Start staff. The Coconino County Community Services Department has a home help program with some staff that may be able to

perform similar services. In addition, some volunteer personnel may have relevant skills for such duties.

Detailed planning for such scenarios, including strategies to measure effectiveness and impact, remains to be completed in subsequent drafts of this plan. It should be noted that there are abundant motel rooms in the county which may be utilized for isolation and quarantine.

Addressing Travel-Related Risk

All activities performed during prior phases will be reviewed and will continue. Information and advisories will continue to be provided to travelers by ADHS and supplemented with local information by the CCHD PIO.

In coordination with national strategies and local healthcare providers, screening of arriving travelers will be initiated at the Grand Canyon and Flagstaff airports, the Flagstaff train station, bus stations and elsewhere as appropriate. Symptomatic or exposed travelers will be isolated or quarantined as appropriate depending upon the phase of the pandemic.

Public Information

CCHD recognizes the importance of maintaining consistency in national, state and local public health messages regarding pandemic influenza. The CCHD Community Relations Manager will seek to reinforce messages distributed by ADHS and supplement this with local information. Once a state of emergency is declared or the State EOC is made operational, coordination of messages will occur through the local Joint Information Center (JIC) and through the Joint Emergency News Center (JENC) at the State EOC.

The IC will assure that all community partners are provided with the most current official information.

All communication with the general public will come from the PIO or designee and will follow procedures discussed in the *CCHD All Hazards Plan, Section 2.0*. General educational messages will stress that the pandemic strain is transmitted in the identical manner as any other strain of influenza. Messages will include information on avoiding catching or transmitting influenza of any type, including standard respiratory and hand washing education.

If not already operational, the call center will be opened and staffed. Refer to the *CCHD All Hazards Plan, Section 4* for more detail.

The PIO will summarize activities of the CCHD for the local media on a regular basis.

The PIO will also monitor media and other sources for rumors and inaccurate information and will promptly respond to correct these so as to minimize concern, social disruption and stigmatization.

During the anticipated decrease in cases between waves of the pandemic, public communication will stress that a second wave is likely and that the community cannot relax general preventive measures.

Continuity of Operations

The CCHD COOP will be discussed and evaluated at each ICS briefing throughout the duration of NIMS activation. CCHD sustained mission essential functions will be continually evaluated and subject to change based on the availability of human resources and equipment/supplies. Changes and/or updates to the CCHDCOOP will be reflected in each Incident Action Plan (IAP).

A primary focus of the Health Department's continuity plan will be to maintain a viable workforce throughout the pandemic response. CCHD may experience up to 30% staff absenteeism throughout the pandemic due to personal and/or family illness, providing childcare or refusal to come to work. In an effort to alleviate this potentially high staff absenteeism, the physical and mental well-being of staff and their families will be emphasized. Throughout the phase 6 response, measures to aide staff physically and mentally will be instated. Some of these measures are outlined below, and others will be developed as the emergency progresses based on staff needs as the emergency progresses.

- “Rest and Recuperation Site” for all on-duty CCHD staff members will be instated *PLACE*.
 - Stocked with: healthy snacks, relaxation materials (movies, music, board games, etc.), communications system so that staff may stay in contact with their families, cots (if needed) and other.
 - Counselors from the Employee Assistance Program (Flagstaff Children's and Family Counseling Center) will be made available.
- The CCHD PIO or designee will send out timely information on the pandemic, the CCHD emergency response, and available support services through county email or other available means of communication. Regular updates will be held twice, daily and on an otherwise as needed basis.
- In the event that greater than 25% of the CCHD are unable to report to work, a secure website will be established as a means for employees to receive timely updates on the emergency response, and available support service.

At this phase, select Coconino County personnel policies will be amended to accommodate staff needs. Such personnel policies include, but are not limited to:

- Staff Travel

CCHD travel policies will be amended following the general guidelines as outlined in the *CCHD All Hazards Plan, Section 7.8*. International and/or domestic travel will be suspended to all areas confirmed or suspected of having human pandemic influenza activity for ALL CCHD staff members. In addition, non-essential travel of ICS-assigned personnel will be suspended.

- Management of Ill Staff

Management of ill staff as outlined in phase 5 will continue, with the following policy additions:

Ill at work

Employees that feel ill or are observed by co-workers with influenza like symptoms should immediately inform their direct supervisor and contact communicable disease manager or designee. The communicable disease manager or designee will then provide the ill employee with a surgical mask and fill out a Suspect Influenza Case form (see Appendix H). The ill employee will be instructed to leave work as soon as possible and advised to contact a health professional. The ill employee's direct supervisor will notify the logistics chief of the personnel change and plans will be made to cover for the sick employee following the lines of succession, if applicable, as outlined in Coconino CCHD All Hazards Plan, Section 7.4.

Isolation of ill employees

Employees that become ill either at work or at home will be required to not return to work until the required isolation period has passed and they are healthy and no longer infectious. After this period, employees will be strongly encouraged to return to work. The duration of the isolation period will be determined by the IC and will be based on the epidemiology of the pandemic influenza strain.

- Employee Compensation

The planning chief will consult with IC and representatives from Coconino County Human Resources Director to solidify employee compensation policies developed in phase 5 that will be appropriate for the extended duration of COOP activation. The Finance/Administration section chief will assure that all employees have prompt access to answers regarding compensation policies.

- Children in the workplace

To assist CCHD staff members to fulfill their job obligations, CCHD will provide childcare accommodations to the best of the agency's ability. Plans to provide childcare will be incorporated into each IAP. Ideally, childcare will be provided at an assigned space at the Department Operations Center (DOC) staffed by CCHD staff member(s). Due to the infectious nature of influenza, infection control practices must guide the planning of childcare accommodations. Please refer to CCHD All Hazards Plan, Section 7.0 for further guidance.

- Telecommuting

Telecommuting will be exercised as a social distancing measure while conducting CCHD operations wherever possible to limit person-to-person contact. CCHD mobile IT equipment (laptops, cellular phones, radios, etc) will, most likely, be dedicated to the pandemic response at the DOC or elsewhere. Therefore, whenever possible, ICS personnel assigned to sustaining CCHD mission essential functions will telecommute

using personnel computers or laptops, cellular phones, land-line phones, etc. All ICS assigned personnel will be asked to carefully record and report telecommuting activities (including hours worked, equipment and/or software used, etc) to the Finance/Administration Section for compensation purposes.

- **Flexible Work Hours**

It is expected that CCHD operations will need to be support operations 24 hours per day, 7 days per week throughout the majority of the influenza pandemic. All ICS-assigned personnel will work in rotating shifts to avoid burn-out. Appropriate rotations to support all CCHD and DOC/EOC operations will be determined and assessed at each ICS briefing and incorporated into the IAP.

Information Management

All information management systems previously described will be used throughout the pandemic period.

D. Recover—Postpandemic Period: Phase 7

Surveillance and Epidemiology

Surveillance activities will return to the inter-pandemic level to the extent possible.

Healthcare Response Coordination

Healthcare partners will be provided current information of the status of the pandemic as it subsides, and will be advised when the pandemic appears to have concluded.

Vaccine and Antiviral Delivery and Administration

Routine influenza vaccination activities will return to the inter-pandemic level to the extent possible.

Community Disease Control

CCHD will follow the lead of ADHS in deactivating the EOC and all ICS activities. Once the influenza pandemic has been declared over, all involved staff will participate in after-action reports and reviews as instructed by the Director.

Addressing Travel-Related Risk

Travelers will be advised, through the media, by the Community Relations Manager when all travel advisories are relieved.

Public Information

The Community Relations Manager will communicate to the public and media that the pandemic is over, and will provide information regarding reviews of activities as authorized by the Director.

Continuity of Operations

Please reference *CCHD All Hazard Plan, Section 7.0.* for further guidance.

Information Management

All activities and database usage will return to that of the interpandemic period.

IV APPENDICES

A Considerations Related to the Pandemic Influenza Vaccine

At the initiation of a pandemic alert, a number of issues related to the vaccine supply become relevant. Influenza vaccine is currently produced by growing virus in live, fertile chicken eggs. For each normal year, a trivalent vaccine is produced – vaccine that produces antibody against a strain of each of three types of influenza: Influenza A H3N2, Influenza A H1N1, and Influenza B. It is a massive undertaking, with the current annual production of less than 100 million doses being the maximum production capacity for the annual trivalent vaccine.

New vaccine is required each year, even though the same general classes of influenza are circulating, i.e. A (H3N2), A (H1N1), and B, partly because slightly different strains circulate each year. The closer the match between the strain and the antibody afforded by the vaccine, the better the protection.

In the event of the need to produce vaccine against a novel strain of influenza, it would require a minimum of three-to-four months to retool the production process before the first vial of vaccine would be produced. If production of routine trivalent vaccine is halted, and production shifts entirely to creating vaccine against only a single strain (the pandemic strain), then three times the number of doses may be created.

However, current U.S. vaccine includes production overseas (in Great Britain), and it is widely assumed that this supplier would not be allowed to ship vaccine to the U.S. during a pandemic, as each nation would seek to maximize its own available supply. There is currently only a single manufacturer that produces influenza vaccine on U.S. soil. This manufacturer's current maximum capacity, if producing only a single-valent vaccine, once the three or four month retooling process is complete, is approximately five million doses per week.

Further complicating this supply is the fact that it is highly likely that persons will require two doses of vaccine, administered one month apart, in order to produce adequate protective antibody against the pandemic strain of influenza. This is because the first exposure to antigen of a novel strain (e.g., first exposure to H1N1 or H3N2 or H5N1) primes the immune system, and the second exposure causes maximum antibody production. The human body requires approximately three weeks to finish making antibody once exposed to the vaccine.

In the event that a totally novel strain arises and leads to a pandemic alert, protection against it by use of vaccine will not be achievable until nearly five months later (minimum of three months to retool production and produce first vaccine plus one month interval before second dose can be given plus three weeks for the body to create antibody).

At this point (five months from the Pandemic Alert) we will begin to see protection of approximately two and a half million Americans per week (five million doses per week at two doses per person). That is approximately one percent of the population. For purposes of this plan, we will assume that once vaccine delivery begins, vaccine for one percent of the County's population, or approximately 1,300 doses, will be delivered through ADHS to CCHD each week.

However, CCHD recognizes that a few recent developments may decrease this length of time. Vaccine against the currently circulating avian influenza A H5N1 has completed clinical trials and appears to be effective in producing antibody in humans. This does not give an accurate indication of vaccine efficacy in protecting against disease, but it is a hopeful sign. The Federal government has committed to purchasing two million doses of this vaccine. If a strain of H5N1 begins to pose a pandemic threat, the availability of this vaccine and the methodology to produce it may allow the County to skip some of the initial three to four month retooling process and allow for more rapid production of more vaccine. However, antigenic drift (minor mutations of influenza) leads to frequent changes in influenza virus and this vaccine may not provide optimal protection against a pandemic strain that arises, even if it is an H5N1 strain. Thus, whether this vaccine will provide us a head start in vaccine production remains to be seen.

Perhaps more importantly, on September 28, 2005, the National Institutes of Allergy and Infectious Disease (NIAID) announced a program with MedImmune to develop vaccine against a myriad of strains of avian influenza. Using reverse genetic and reassortment techniques, they hope to produce vaccine against a existing and potential classes of avian influenza. This would jump start the future production of vaccine against a likely pandemic strain, and would cut some months off the production timeline. Research is also underway in production techniques that do not require fertile eggs, making it easier to vastly increase production capacity.

As of the draft date of this report, however, neither of the last two breakthroughs discussed above have been accomplished, and it must be assumed that there will not be an adequate supply of vaccine on hand at the start of a pandemic. It is also a reasonable assumption that once delivery begins, vaccine will be forthcoming in small quantities (approximately one percent of the County's population per week). As circumstances change, this aspect of this plan will be revised.

Given all of the above information, it is assumed that the process of vaccine production against a potential pandemic strain will begin at the point of a Pandemic Alert.

B Graded Implementation of Voluntary and Regulatory Social Distancing Measures

CDC PANDEMIC PHASE	LEVEL OF INFLUENZA ACTIVITY IN COCONINO COUNTY	RECOMMENDED PANDEMIC MANAGEMENT/ SOCIAL DISTANCING ACTIONS	REGULATORY SOCIAL DISTANCING ACTIONS	ENTITY WITH AUTHORITY TO ACT & ENFORCE
3	Novel influenza virus infecting humans abroad; no human-to-human transmission; no cases in the U.S.	<ul style="list-style-type: none"> • Preparedness planning with partners • Business and government continuity planning • Educate response partners • Initiate public education campaign • Special attention given to promoting seasonal influenza vaccine and public hygiene among at-risk and general population • Community relations manager provides information to local travelers who visit countries where novel influenza strains are reportedly infecting humans 	NA	NA
4	Small clusters abroad with limited human-to-human transmission. Small number of cases may begin appearing in the United States and/or Southwestern US ; all are either imported or do not have clear epidemiologic links to other cases.	<ul style="list-style-type: none"> • All measures in Phase 3 • Recommend Coconino County residents defer travel to countries or areas of the U.S. impacted by the novel virus, as per CDC guidance • CCHD will initiate active surveillance for influenza or increased absenteeism from schools and large employers. • EOC convened for bi-weekly briefings on disease progression • Public information would be coordinated by a Joint Information Committee (JIC) 	<ul style="list-style-type: none"> • Isolation of all cases • Quarantine of close contacts 	Coconino County Health Officer
5	Larger clusters , but spread is still localized . A larger number of cases (approximately 30) appear in the United States and/or Coconino County , still without clear epidemiologic link to other cases and/or evidence of increased occurrence of influenza among close contacts .	<ul style="list-style-type: none"> • All measures in Phase 4 • Recommend residents avoid close contact with other persons to the extent possible by curtailing travel and non-essential contact with other persons • Essential businesses and organizations may need to activate their COOP (refer to list of essential services) • Ill staff should be reminded that they should not report to work • Weekly EOC briefings • Public information managed by JIC/EOC briefings. The media will be the major source of information for the public and coordinated by the JIC <p>Other sources of information, such as the 211 system and a call center will be referenced as appropriate</p>	<ul style="list-style-type: none"> • Isolation of all cases • Quarantine of close contacts 	Coconino County Health Officer

<p>6a (not local)</p>	<p>Sustained novel influenza virus transmission in United States with a large number of confirmed cases identified with clear epidemiologic link and increased occurrence of influenza among close contacts.</p>	<ul style="list-style-type: none"> • All measures in Phase 5 • Encourage government and businesses to implement emergency staffing plans • Recommend public transit be used only for essential travel • EOC operational 12 hours a day/ 7 days per week • Detection of the novel influenza virus in Coconino County will be a high priority 	<ul style="list-style-type: none"> • Isolation of all cases • Monitoring of all contacts of cases • Coordinated screening of all travelers entering Coconino County • Cancel all large public gatherings 	<p>Coconino County Health Officer</p> <p>Superintendents of schools</p> <p>Presidents of the University and Community College</p> <p>Business/ organization owners and managers</p> <p>**Coconino County Health Officer maintains jurisdiction over local activities, though individual managers/ superintendents may act preemptively</p>
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<p>6b (local)</p>	<p>Sustained novel influenza activity in Coconino County with widespread, countywide impact</p>	<ul style="list-style-type: none"> • All measures in Phases 5 & 6a • EOC operational 24 hours a day/ 7 days per week • Consideration of a declaration of a local state of emergency • Consider suspending government functions not dedicated to pandemic response or critical continuity 	<ul style="list-style-type: none"> • Close educational facilities, libraries, large day care centers • Close churches, theaters, stadiums, community centers, malls, athletic events 	<p>Coconino County Health Officer</p> <p>Superintendents of schools</p> <p>Presidents of the University and Community College</p> <p>Business/ organization owners and managers</p> <p>**Coconino County Health Officer maintains jurisdiction over local activities, though individual managers/ superintendents may act preemptively</p>
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C Applicable Statutes and Laws

ARS 26-310. Use of Professional Skills

During a state of war emergency or state of emergency, any person holding any license, certificate, or other permit issued by any state evidencing the meeting of qualification of such state for professional skills may render aid involving such skill to meet the emergency as fully as if such license had been issued in this state.

ARS 23-901.06 Volunteer Workers

In addition to persons defined as employees under section 23-901, volunteer workers of a county, city, town, or other political subdivision of the state may be deemed to be employees and entitled to the benefits provided by this chapter upon the passage of a resolution or ordinance by the political subdivision defining the nature and type of volunteer work and workers to be entitled to such benefits. The basis for computing compensation benefits and premium payments shall be four hundred dollars per month.

ARS 26-314 Immunity of State, Political Subdivisions and Officers, Agents, and Emergency Workers; Limitation Rules

The Department, ADHS or any other state agency, will not be liable for any claim based upon the exercise or performance, or the failure to exercise or perform, a discretionary function or duty by an emergency worker, engaging in emergency management activities or performing emergency functions. This state and its departments, agencies, boards and commissions and all other political subdivisions that supervise or control emergency workers engaging in emergency activities or emergency functions are responsible for providing for liability coverage, including legal defense, of an emergency worker if necessary. Coverage provided if the emergency worker is acting within the course and scope of assigned duties and is engaged in an authorized activity, except for actions of willful misconduct, gross negligence or bad faith.

ARS 36-184. Boards of health of local health departments; organization; meetings; powers and duties

This article does not authorize a county health department or any of its officers or representatives to impose on any person any mode of treatment against that person's will, or any examination inconsistent with the creed or tenets of any religious denomination of which the person is an adherent, provided that the person complies with sanitary and quarantine laws, rules and regulations.

ARS 36-624. Quarantine and sanitary measures to prevent contagion

When a county health department or public health services district is apprised that infectious or contagious disease exists within its jurisdiction, it shall immediately make an investigation. If the investigation discloses that the disease does exist, the county health department or public health services district may adopt quarantine and sanitary measures consistent with department rules

and sections 36-788 and 36-789 to prevent the spread of the disease. The county health department or public health services district shall immediately notify the department of health services of the existence and nature of the disease and measures taken concerning it.

ARS 36-627. Temporary hospitals for persons with contagious disease

A local board of health or health department may provide a temporary hospital or place of reception for persons with infectious or contagious diseases. Hospitals or other places in which infectious or contagious disease exists shall be under the control and subject to regulations of the local board of health or health department while such disease exists. During such periods of hospital control, inmates shall obey the regulations and instructions of the local board or department.

ARS 36-782. Enhanced surveillance advisory

A. The director shall notify local health authorities before the governor issues an enhanced surveillance advisory. The department and local health authorities shall provide the enhanced surveillance advisory to those persons and entities required by the advisory to report pursuant to this article by using any available means of communication. This article does not alter the department's or a local health authority's ability to monitor community health status or implement control measures for the early detection of communicable and preventable diseases otherwise allowed by law.

B. Before the governor issues an enhanced surveillance advisory, the department and local health authorities must meet with representatives of persons or institutions who will be affected by the enhanced surveillance advisory pursuant to section 36-783, subsections A, B and C. If, because of an immediate threat to the public health, the department and local health authorities are not able to hold this meeting before the governor issues the advisory, the meeting must take place within seventy-two hours after the governor issues the advisory.

C. To the extent possible, the department and local health authorities shall share department and local health authority personnel, equipment, materials, supplies and other resources to assist persons and institutions affected to implement the terms of the advisory.

ARS 36-784. Patient tracking during enhanced surveillance advisory

A. During an enhanced surveillance advisory, to identify, diagnose, treat and track persons who may have been exposed to an illness or health condition caused by bioterrorism, pandemic influenza or a highly fatal or highly infectious agent or biological toxin, the department and local health authority may access confidential patient information, including medical records, wherever and by whomever held and whether or not patient identity is known.

B. The department or local health authority shall counsel and interview any person as necessary to assist it in the positive identification of exposed persons and to develop information relating to the source and spread of the illness or health condition. This information must include the names

and addresses of any persons from whom the illness or health condition may have been contracted and to whom the illness or health condition may have spread.

C. Any medical information or other information from which a person or a person's family might be identified that is received by the department or local health authority in the course of an enhanced surveillance advisory is confidential and is not available to the public.

ARS 36-785. Information sharing during an enhanced surveillance advisory

A. during an enhanced surveillance advisory, whenever a public safety authority learns of a suspicious disease event or a threatened bioterrorism act, it shall immediately notify the department or the local health authority, and the agency that receives this information must immediately notify the other agency.

B. when the department or the local health authority identifies a reportable illness or health condition, unusual disease cluster or suspicious disease event that it reasonably believes may be caused by bioterrorism, the department or local health authority must immediately notify the appropriate public safety authority and, if appropriate, tribal health authorities.

C. sharing of information on reportable illnesses, health conditions, unusual disease clusters or suspicious disease events between public safety and local health authorities is limited to the information necessary to affect the enhanced surveillance advisory. Information from which a person or a person's family might be identified that is received by the department, local health authority or public safety authority in the course of an enhanced surveillance advisory is confidential and not available to the public.

ARS 36-786. Laboratory testing during an enhanced surveillance advisory

A. The state laboratory shall coordinate specimen testing during an enhanced surveillance advisory. If necessary and at state expense, the department may designate alternative or secondary laboratories to assist it in testing specimens.

b. The department shall determine the criteria necessary for private or public laboratories to conduct clinical or environmental testing associated with bioterrorism or any illness or health condition subject to the enhanced surveillance advisory.

c. During an enhanced surveillance advisory, a public safety authority, if requested by the department or local health authority, shall coordinate and provide transportation of clinical or environmental samples to the state laboratory or other testing laboratory designated by the department.

ARS 36-787. Public health authority during state of emergency

A. During a state of emergency declared by the governor in which there is an occurrence or imminent threat of an illness or health condition caused by bioterrorism, an epidemic or pandemic disease or a highly fatal infectious agent or biological toxin and that poses a

substantial risk of a significant number of human fatalities or incidents of permanent or long-term disability, the department shall coordinate all matters pertaining to the public health emergency response of the state. The department has primary jurisdiction, responsibility and authority for:

1. Planning and executing public health emergency assessment, mitigation, preparedness response and recovery for this state.
2. Coordinating public health emergency response among state, local and tribal authorities.
3. Collaborating with relevant federal government authorities, elected officials of other states, private organizations and private sector companies.
4. Coordinating recovery operations and mitigation initiatives subsequent to public health emergencies.
5. Organizing public information activities regarding state public health emergency response operations.

B. In addition to the authority provided in subsection a, during a state of emergency, the governor, in consultation with the director of the department of health services, may issue orders that:

1. Mandate medical examinations for exposed persons.
2. Ration medicine and vaccines.
3. Mandate treatment or vaccination of persons who are diagnosed with illness resulting from exposure or who are reasonably believed to have been exposed or who may reasonably be expected to be exposed.
4. Provide for transportation.
5. Isolate and quarantine persons.
6. Provide for procurement of medicines and vaccines.

C. Law enforcement officials of this state and the national guard shall enforce orders issued by the governor under this section.

D. This section does not apply to persons with acquired immune deficiency syndrome or other infection caused by the human immunodeficiency virus.

36-788. Isolation and quarantine during a state of emergency or state of war emergency

A. The department or local health authority may, during the state of emergency or state of war emergency declared by the governor, do the following:

1. Establish and maintain places of isolation and quarantine, which may include the residence of the person quarantined.
2. Require isolation or quarantine of any person by the least restrictive means necessary to protect the public health. The department or local health authority shall use all reasonable means to prevent the transmission of disease among the isolated or quarantined persons.

B. The department, a county health department or a public health services district shall ensure, to the extent possible, that the premises in which a person is isolated or quarantined is maintained in a safe and hygienic manner and is designed to minimize the likelihood of further transmission of disease or other harm to a person subject to isolation or quarantine. Adequate food, clothing, medication and other necessities, competent medical care and means of communicating with those in and outside these settings shall be made available.

C. A person subject to isolation or quarantine shall comply with the department's or local health authority's rules and orders, shall not go beyond the isolation or quarantine premises and shall not come in contact with any person not subject to isolation or quarantine other than a physician or other health care provider, department or local health authority or person authorized to enter an isolation or quarantine premises by the department or local health authority.

D. Other than a person authorized by the department or local health authority, a person shall not enter an isolation or quarantine premises. If, by reason of an unauthorized entry into an isolation or quarantine premises, the person poses a danger to public health, the department, or local health authority may place the person in isolation or quarantine pursuant to this section or section 36-789.

E. The department, or local health authority, must terminate isolation or quarantine of a person if it determines that the isolation or quarantine is no longer necessary to protect the public health.

36-789. Due process for isolation and quarantine during a state of emergency or state of war emergency

A. The department, or local health authority, may isolate or quarantine a person or group of persons through a written directive without first obtaining a written order from the court if any delay in the isolation or quarantine of the person would pose an immediate and serious threat to the public health. The directive shall:

1. Specify the identity of the person or persons subject to isolation or quarantine, the premises subject to isolation or quarantine, the date and time at which isolation or

quarantine commences, the suspected highly contagious and fatal disease, if known, and that a state of emergency has been declared by the governor.

2. Be given to the person or persons to be isolated or quarantined. If the directive applies to groups of persons and it is impractical to provide individual copies, it may be posted in a conspicuous place in the isolation or quarantine premises.

B. Within ten days after issuing the written directive, or when any delay in the isolation or quarantine of a person or group of persons will not pose an immediate and serious threat to the public health, the department or local health authority shall file a petition for a court order authorizing the initial or continued isolation or quarantine of a person or group of persons. The petition shall specify the following:

1. The identity of the person or group of persons subject to isolation or quarantine.

2. The premises subject to isolation or quarantine.

3. The date and time at which isolation or quarantine commences.

4. The suspected contagious disease, if known.

5. A statement of compliance with the conditions and principles for isolation and quarantine.

6. A statement of the basis on which isolation or quarantine is justified pursuant to this article.

C. The petition must be accompanied by the sworn affidavit of the department or local health authority attesting to the facts asserted in the petition, together with any further information that may be relevant and material to the court's consideration.

D. Notice to a person or group of persons identified in a petition filed pursuant to subsection B of this section must be completed within twenty-four hours after filing the petition and in accordance with the rules of civil procedure.

E. A hearing must be held on a petition filed pursuant to this section within five days after filing of the petition. In extraordinary circumstances and for good cause shown, the department or local health authority may apply to continue the hearing date on a petition for not more than ten days. If the court grants a continuance it must give due regard to the rights of the affected persons, the protection of the public's health, the severity of the emergency and the availability of necessary witnesses and evidence.

F. The court shall grant the petition if, by a preponderance of the evidence, isolation or quarantine is shown to be reasonably necessary to protect the public health.

G. A court order authorizing isolation or quarantine may do so for a period not to exceed thirty days. The order must:

1. Identify the isolated or quarantined person or group of persons by name or shared or similar characteristics or circumstances.
2. Specify factual findings warranting isolation or quarantine pursuant to this article, including any conditions necessary to ensure that isolation or quarantine is carried out within the stated purposes and restrictions of this article.
3. Be served on an affected person or group of persons in accordance with the rules of civil procedure.

H. Before an isolation or quarantine order expires, the department or local health authority may move to continue the isolation or quarantine for an additional period not to exceed thirty days. The court shall grant the motion if, by a preponderance of the evidence, isolation or quarantine is shown to be reasonably necessary to protect the public health.

I. A person or group of persons isolated or quarantined pursuant to this section may apply to the court for an order to show cause why the person or group of persons should not be released. The court must rule on the application to show cause within forty-eight hours after it is filed. If the court grants the application, the court must schedule a hearing on the order to show cause within twenty-four hours after it issues the order to show cause. The issuance of an order to show cause does not stay or enjoin an isolation or quarantine order.

J. A person isolated or quarantined pursuant to this section may request a court hearing regarding the person's treatment and the conditions of the quarantine or isolation.

K. On receiving a request for a hearing pursuant to subsection J of this section, the court must set a date for a hearing. The hearing must take place within ten days after the court receives the request. The request for a hearing does not alter the order of isolation or quarantine. If the court finds that the isolation or quarantine of the person or group of persons does not comply with the requirements of this section or section 36-788, the court may provide remedies appropriate to the circumstances of the state of emergency, the rights of the individual and in keeping with the provisions of this article.

L. A record of the proceedings pursuant to this section shall be made and retained. If, because of a state of emergency or state of war emergency declared pursuant to section 36-787, parties cannot personally appear before the court, the proceedings may be conducted by the authorized representatives of the parties and held by any means that allows all parties to fully participate.

M. The court shall appoint counsel at state expense to represent a person or group of persons who is subject to isolation or quarantine pursuant to this article and who is not otherwise represented by counsel. Representation by appointed counsel continues throughout the duration of the isolation or quarantine of the person or group of persons. The department or local health

authority must provide adequate means of communication between the isolated or quarantined persons and their counsel.

N. In any proceedings brought pursuant to this section, to promote the fair and efficient operation of justice and having given due regard to the rights of the affected persons, the protection of the public's health, the severity of the emergency and the availability of necessary witnesses and evidence, the court may order the consolidation of individual claims into groups of claims if:

1. The number of persons involved or to be affected is so large as to render individual participation impractical.
2. There are questions of law or fact common to the individual claims or rights to be determined.
3. The group claims or rights to be determined are typical of the affected person's claims or rights.
4. The entire group will be adequately represented in the consolidation.

36-790. Privileges and immunities

A. The physician patient privilege does not prevent a person or health care provider from complying with the duty to report or provide personal information and medical information to the department or local health authority in accordance with this article. The department and local health authorities shall maintain the confidentiality of the medical information and personal identifiers received.

B. A person or health care provider undertaking any activity required by this article, including reporting, participating in quarantine or isolation procedures, is immune from civil or criminal liability if the person or health care provider acted in good faith. Actions required by this article are presumed to be in good faith.

C. The immunities prescribed in section 26-314 are applicable to sections 36-787, 36-788 and 36-789.

D Needs Assessment of Infection Control Guidelines in Coconino County Clinics and Hospitals

Tasks	Not Started	In Progress	Done
An infection control plan is in place and includes the following: (For more information on infection control recommendations for pandemic influenza see www.hhs.gov/pandemicflu/plan/sup4.html)			
A specific waiting room location has been designated for patients with symptoms of pandemic influenza that is segregated from other patients awaiting care. (This may not be feasible in very small waiting rooms, in which case the emphasis may be on use of masks as noted below)	Concentra	North Country; FMC; Page Hospital; Tuba City Hospital	
A plan for implementing respiratory hygiene/cough etiquette is in place. (For more information see www.cdc.gov/flu/professionals/infectioncontrol/resphgiene.htm)		North Country; Concentra; Page Hospital	FMC; Tuba City Hospital
Signage (language appropriate) directing patients and those accompanying them to notify reception personnel if they have symptoms of pandemic influenza has been developed or a source of signage (e.g., CDC website above) has been identified.	North Country	Concentra; Page Hospital; Tuba City Hospital	FMC
Signage (language appropriate) on Respiratory Hygiene/Cough Etiquette instructing symptomatic persons to use tissues to cover their cough to contain respiratory secretions and perform hand hygiene has been developed or a source of signage (e.g., CDC website above) has been identified.		Tuba City Hospital	North Country; Concentra; FMC; Page Hospital

Tasks	Not Started	In Progress	Done
The plan includes distributing masks to symptomatic patients who are able to wear them (adult and pediatric sizes should be available), providing facial tissues, receptacles for their disposal and hand hygiene materials in waiting areas and examination rooms.		North Country; Page Hospital	Concentra; FMC; Tuba City Hospital
Implementation of Respiratory Hygiene/Cough Etiquette has been exercised during seasons when influenza and other respiratory viruses (e.g., respiratory syncytial virus, parainfluenza virus) are circulating in communities.		North Country; Concentra	FMC; Page Hospital; Tuba City Hospital
If patients with pandemic influenza will be evaluated in the same location as patients without an influenza-like illness, separate examination rooms have been designated for evaluation of patients with symptoms of pandemic influenza.		North Country; FMC	Concentra; Page Hospital; Tuba City Hospital
A policy is in place that requires healthcare personnel to use Standard (www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html) and Droplet Precautions (i.e., mask for close contact) (www.cdc.gov/ncidod/dhqp/gl_isolation_droplet.html) with symptomatic patients.		Concentra	North Country; FMC; Page Hospital; Tuba City Hospital
The policy includes protection of reception and triage personnel at initial points of patient encounter.		Concentra	North Country; FMC; Page Hospital; Tuba City Hospital

E Coconino County Influenza Vaccination Estimation Worksheet

Tiers	Pandemic Priority Groups	Estimated Populations			Coconino County No. of Doses (2 doses per person)
		United States	Arizona	Coconino County	
ALL	Total Population	312,000,000	5,832,150	123,866	247,732
1A	Vaccine & antiviral manufacturers	~40,000	~800	~16	~32
1A	Medical workers and public health workers w/ direct patient care	~8.0 to 9.0 million	~160,000-180,000	~3,200 – 3,600	~6,400-7,200
1B	Persons ≥65 yrs w/ 1 or more high-risk conditions	~18.2 million	~364,000	~7,280	~14,560
1B	Persons 6 months to 64 w/ 2 or more high-risk conditions	~6.9 million	~138,000	~2,760	~5520
1B	Persons 6 months or older w/ hx of hospitalization for pneumonia or influenza in past year	~740,000	~14,800	~296	~592
1C	Pregnant women	~30 million	~600,000	~12,000	~24,000
1C	Household contacts of severely immunocompromised persons who could not receive vaccine	~2.7 million	~54,000	~1,080	~2,160
1C	Household contact of children <6 months old	~5.0 million	~100,000	~2,000	~4,000
1D	Public health emergency response workers critical to pandemic response	~150,000	~3,000	~60	~120
1D	Key government leaders	TBD	TBD	TBD	
2A	Healthy persons 65 yrs and older	~17.7 million	~354,000	~7,080	~14,160
2A	Persons 6 months to 64 yrs w/ 1 high-risk condition	~35.8 million	~716,000	~14,320	~28,640
2A	Healthy children 6-23 months old	~5.6 million	~112,000	~2,240	~4,480
2B	Other public health emergency responders	~300,000	~6,000	~120	~240
2B	Public safety workers including police, fire, 911 dispatchers and correctional facility staff	2.99 million	59,800	1,196	2,392
2B	Utility workers essential for maintenance of power, water and sewage	364,000	7,280	146	292
2B	Transportation workers transporting fuel, water, food and medical supplies	3.8 million	76,000	1,520	3,040
2B	Telecommunications/IT for essential network operations and maintenance	1.08 million	21,600	432	864
3	Other key government health decision-makers	TBD	TBD	TBD	TBD
3	Funeral directors/embalmers	62,000	1,240	25	50
4	Healthy persons 2-62 yrs not included in other categories	~179.3 million	~3,026,630	60,533	121,066
Based on ADHS priority Groups Resource: Arizona Influenza Pandemic Response Plan, ADHS, June 2006 Assumptions: 2004 Census data and AZ/US ratio ~2% and Coconino County/AZ ratio ~2%					

F. Coconino County Antiviral Use Estimation Worksheet

	Priority Group	Strategy	Estimated Population			C.F.	Target Group (Number of Tx courses-10 pills/course)	Cumulative Courses	
			US (millions)	AZ	Coconino County				
1	Patients admitted to hospital	Treat	10.0	200,000	4,000	75%	3,000	3,000	Treat those seriously ill and most likely to die
2	HCWs with direct patient care and EMS	Treat	9.2	184,000	3,680	25%	920	3,910	HCWs needed for medical care
3	Highest risk outpatients: pregnant women; immuno-compromised	Treat	2.5	50,000	1,000	25%	250	4,170	Highest risk of hospitalization and death; hard to protect immuno-compromised by vaccine
4	Pandemic health responders, Public Safety, Government decision-makers	Treat	3.3	66,000	1,320	25%	330	4,500	Critical for effective public health response
5	Increased risk patients: ages 12-23 months, ≥65 yrs.; underlying medical conditions	Treat	85.5	1,710,000	34,200	25%	8,550	13,050	High risk for hospitalization and death
6	Outbreak response	Post Exposure Prophyl.	~2 million	~40,000	~800	2%	800	13,850	Treatment & prophylaxis to contacts stop outbreaks
7	HCWs in emergency departments, ICU, EMS, dialysis centers	Prophyl.	1.2	24,000	480	X4	1,920	3,305	Most critical to prevent absenteeism and surge capacity response
8	Pandemic societal responders & HCWs without direct patient contact	Treat	10.2	204,000	4,080	25%	1,020	34,070	Impact on maintaining health, implementing pandemic response, maintaining societal functions
9	Other outpatients	Treat	180	3,600,000	72,000	25%	18,000	443,875	Those who develop influenza and do not fit in above groups

10	Highest risk outpatients	Prophy.	2.5	50,000	1,000	X4	4,000	39,510	Prevents illness in highest risk groups
11	Other HCWs with direct patient contact	Prophy.	8.0	160,000	3,200	X4	12,800	52,310	Reduce absenteeism and preserve optimal health care response
Based on ADHS priority Groups Resource: Arizona Influenza Pandemic Response Plan, ADHS, June 2006 Assumptions: 2004 Census data and AZ/US ratio ~2% and Coconino County/AZ ratio ~2%									

C.F. = Conversion Factors: Mirroring assumptions in HHS PIP 11-05 document for U.S.

- 75% of hospitalized patients would get treated.
- 25% of select priority groups would get infected and need treatment.
- Two million people in the US may need Post Exposure Prophylaxis (PEP); 2% of that = 40,000
- X4 derives from the average need for prophylaxis for select priority groups would be the equivalent of 4 treatment courses (20 days or forty 75 mg pills)

G Influenza versus Common Cold

SYMPTOM	INFLUENZA	COMMON COLD
Fever	Usual, sudden onset 38 o - 40 o and lasts 3-4 days.	Rare
Headache	Usual and can be severe	Rare
Aches and pains	Usual and can be severe	Rare
Fatigue and weakness	Usual and can last 2-3 weeks or more after the acute illness	Sometimes, but mild
Debilitating fatigue	Usual, early onset can be severe	Rare
Nausea, vomiting, diarrhea	In children <5 years old	Rare
Watering of the eyes	Rare	Usual
Runny, stuffy nose	Rare	Usual
Sneezing	Rare in early stages	Usual
Sore throat	Usual	Usual
Chest discomfort	Usual and can be severe	Sometimes, but mild to moderate
Complications	Respiratory failure; can worsen a current chronic condition; can be life threatening	Congestion or ear-ache
Fatalities	Well recognized	Not reported
Prevention	Influenza vaccine; frequent hand- washing; cover your cough	Frequent hand-washing, cover your cough

H Suspect Influenza Case Form

For management of staff who become ill at work
-Draft until one is provided by ADHS-

Details of affected employee

Name:	Date:	<input type="checkbox"/> Visitor <input type="checkbox"/> Employee	Date of Birth:
Job Title:	Worksite:	Location of Isolation:	
Address:			
Telephone No: _____ (w) _____ (h) _____ (other)			
Symptoms noticed: <input type="checkbox"/> Fever Time of fever on-set: _____ <input type="checkbox"/> Headache Time of isolation: _____ <input type="checkbox"/> Dry cough Date expected to return to work: _____ <input type="checkbox"/> Cold <input type="checkbox"/> Body aches <input type="checkbox"/> Fatigue <input type="checkbox"/> Other: _____			
Where referred:			
Notes:			
Close Contacts during previous 2 days:			
Name:	Email:	Telephone no:	Address:
1.			
2.			
3.			
4.			
5.			
6.			

Details of reporter:

Name:
Job title:
Telephone No: _____ (w) _____ (h) _____ (other)